NATIONAL ASSOCIATION OF RURAL HEALTH CLINICS

September 11, 2023

The Honorable Chiquita Brooks-LaSure, Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1784-P
P.O. Box 8016
Baltimore, MD 21244–8016

Dear Administrator Brooks-LaSure:

On behalf of the National Association of Rural Health Clinics (NARHC) and the over 5,300 federally certified Rural Health Clinics (RHC), we are pleased to provide the following comments on the proposed 2024 Medicare Physician Fee Schedule (PFS). Our comments are focused on the following issues:

- Telehealth
- New RHC Billable Providers: Marriage and Family Therapists and Mental Health Counselors
- Care Management
    - New Care Management Codes Billable as G0511
    - Revision to G0511 Payment Methodology
    - Beneficiary Consent Clarification
    - Social Determinants of Health G-Code
- Conditions of Certification: Nurse Practitioner Definition Change
- Other Provisions Not Addressed

Telehealth

NARHC appreciates the continued telehealth flexibilities granted by Congress in the Consolidated Appropriations Act of 2023, extending RHCs' ability to provide telehealth services through December 31, 2024, and for the conforming technical changes made by CMS in this proposed rule to reflect the policies.

NARHC continues to advocate to Congress on ultimate RHC telehealth priorities: incorporation of medical telehealth services into the definition of a medical RHC visit, allowing RHCs to be reimbursed at their all-inclusive rate, reducing administrative burden, and ensuring that safety-net providers are not disadvantaged in offering these services, in comparison to fee-for-service providers. Given the extension of current RHC medical telehealth policy; however, billing G2025 for all allowable Medicare telehealth services, through December 31, 2024, NARHC requests that CMS further consider their authority to implement normal coding within the "special payment rule" authorized by Congress. NARHC argues that the special payment can be indicated through a modifier code (95) in order to better facilitate data collection of RHC services performed via telehealth, including proper counting of Annual Wellness

Visits and other preventive services. We look forward to engaging in continued conversations with CMS on RHC telehealth flexibilities.

CMS proposes to allow for direct supervision of incident-to services (presence and immediate availability) via telecommunications technology through December 31, 2024, and requests comments on whether this flexibility should continue after such date. NARHC is supportive of making this flexibility permanent for incident-to services, and we have no program integrity concerns regarding this policy. Auxiliary personnel would never be providing clinical care to patients without a qualified RHC provider on-site for compliance with a separate requirement; however, this flexibility for virtual direct supervision may decrease inefficiencies when the on-site provider is unable to supervise that particular service.

Finally, NARHC requests guidance from CMS to clarify for the RHC community if distant site telehealth services may be provided outside the RHC's hours of operations. NARHC believes that RHCs should not be limited to only offering telehealth during the hours of operation of the physical RHC as such a policy would only limit access to care for safety-net patients.

New RHC Billable Providers: Marriage and Family Therapists and Mental Health Counselors

NARHC appreciates Congress extending Medicare coverage to Marriage and Family Therapists (MFTs) and Mental Health Counselors (MHCs) practicing in RHCs beginning January 1, 2024, and thanks CMS for providing further details on implementing this new coverage consistent with the statute. Further, NARHC appreciates CMS allowing addiction counselors who meet all of the applicable requirements to enroll in Medicare as MHCs. **NARHC is supportive of the proposed authority of coverage, definitions of MFTs and MHCs, payment provisions for RHCs, and all related regulatory changes.** We believe that these additional provider types will assist RHCs in expanding the greatly needed behavioral health services for their patients while maximizing the available behavioral health workforce.

NARHC assumes that MFTs and MHCs will **not** be subject to a productivity standard as is required for physicians, NPs, PAs, and CNMs in the RHC setting, but **requests confirmation** from CMS.

Care Management

Since 2016, RHCs have been able to bill for care management services through a consolidated care management code: G0511. Over the last several years, the services eligible for reimbursement through G0511 have expanded and now include: Chronic Care Management (CCM), Principal Care Management (PCM), General Behavioral Health Integration (GBHI), and Chronic Pain Management (CPM). As safety net providers, RHCs have long been providing comprehensive care beyond the confines of a standard visit, and NARHC commends CMS for retaining a mechanism for RHCs to provide and bill for these services that would not fit our traditional definition of a reimbursable encounter.

When billed using G0511, RHCs receive a consolidated fee schedule amount for these services furnished by a physician or other qualified health care professional-- reimbursing at $77.94 in 2023.

New Care Management Codes Billable as G0511

In this year's rule, CMS proposes to further expand services billable by RHCs under the G0511, general care management code, including Remote Patient Monitoring (RPM), Remote Therapeutic Monitoring (RTM), Principal Illness Navigation (PIN), and Community Health Integration (CHI).
For years, NARHC has been advocating for CMS to extend RPM and RTM billing privileges to safety net providers, and NARHC commends CMS for retaining a mechanism for RHCs to provide and bill for these services. Additionally, we appreciate the creation of the new CHI and PIN codes in acknowledgment of the care and social services provided by auxiliary members of a care team.

However, if the proposed rule is finalized as written, beginning in 2024, the G0511 code will be the special payment code that represents over 20 care management services, and this aggregation presents a myriad of problems.

The Medicare Claims Processing Manual Chapter 9 states "HCPCS code G0511 or G0512 can only be billed once per month per beneficiary and cannot be billed if other care management services are billed for the same time period." Therefore, if an RHC patient is already enrolled in a clinic's CCM program, regardless of whether they may benefit from additional services like RPM, CHI, etc.; the RHC will only be eligible for one G0511 reimbursement for that patient each month. This differs from fee-for-service flexibilities, in that FFS providers can bill RPM, CCM, CHI, and PIN all for the same patient, in the same month, so long as time and services are not duplicative.

Unless CMS changes their policy to allow multiple G0511 services per patient per month, or considers other approaches as outlined below, safety-net providers and our patients are put at a disadvantage by this special payment rule. Further, the continued consolidation of many services into one billable code presents numerous challenges for RHCs participating in value-based care arrangements for which they are required to track the specific care management services they provide to their patients.

Ultimately, in alignment with CMS thinking on the immense value of these care management services and the complexities of patient care that go well beyond a traditional office visit, we implore CMS to consider one, or a combination of, the below approaches to care management in the RHC setting.

Solution 1
CMS could allow G0511 to be billed multiple times per patient per month, using modifiers to indicate which care management service was provided. RHCs would be subject to the same rules as fee-for-service providers as to which services could be billed in the same month, and which are mutually exclusive.

Pros:

- This policy is the most similar to current G0511 policy but allows certain care management services to be billed for the same patient in the same month, increasing safety net patient access to these important services.

Cons:

- The use of up to 20 modifiers may become an unwieldy methodology that requires continuous updating as additional care management services are added in future years.
- Fee-for-service providers are eligible to bill for CCM on a time-based (add-on) methodology, in addition to the initial codes. Proposed solution 1 would not permit RHCs

to bill for these additional minutes, nor the device and set-up codes that FFS providers can bill for separately amongst the suite of RPM/RTM codes.

Solution 2

CMS could create a more comprehensive set of G-codes that are separated by service type, or by time. For example:

- G0511 remains the consolidated code for CCM, PCM, CPM
- NEW G0513 RPM
- NEW G0514 RTM
- NEW G0515 PIN
- NEW G0516 CHI

Pros:

- This proposal allows RHCs to indicate which category of care management services they are providing, which would allow CCM and PIN, for example, to be billed on the same claim and be reimbursed for the same patient in the same month.

Cons:

- Like solution 1, this proposal would not permit RHCs to bill for these additional minutes, nor the device and set-up codes that FFS providers can bill for separately amongst the suite of RPM/RTM codes.

Solution 3

CMS could allow RHCs to bill for the full suite of care management codes, the same way (or similarly) to how a traditional fee-for-service provider, or hospital outpatient department bills for care management. NARHC appreciates that CMS has created special payment rules (G-codes) for services outside of the RHC encounter in order to both ensure safety-net providers have the ability to bill for these services, and also to limit administrative burden by consolidating the codes. However, as the care management services expand, the process has become burdensome, without allowing RHC patients and their providers to see the full benefits of these expanded billable services. Considering a more traditional fee-for-service style methodology could reduce these complexities and associated burdens of a separate coding and billing structure. Further, freestanding RHCs already bill the Medicare physician fee schedule on a CMS-1500 form for laboratory services and the technical component of diagnostic services.

Pros:

- Following the coding rules of fee-for-service providers for care management services would allow RHCs to bill for the full suite of care management services with the proper CPT code. Additionally, RHCs would be able to bill add-on codes for additional minutes spent on such services, as well as the device and setup codes for RPM/RTM services.

Cons:

- We recognize that this may not be an immediately feasible solution, and there may be additional technical concerns for hospital-owned RHCs using this style of billing.

While NARHC hopes that it is the intent of CMS to allow RHC providers and their patients to participate in the full benefits of these expanded care management codes, current guidance clearly does not allow for this. RHCs remain essential in providing comprehensive care to underserved populations and to do so, should have equal access to reimbursement for these enhanced digital health services. **We ask for further guidance as to how RHCs can participate in the full suite of these opportunities beginning in 2024.**

Revision to G0511 Payment Methodology
NARHC appreciates CMS considering revisions to the consolidated care management reimbursement rate as additional billable codes that reimburse at a lower amount are added, lowering the true average. **We are supportive of utilizing a weighted average for a more accurate reimbursement,** however as CMS notes, the utilization data must be pulled from traditional fee-for-service offices because CMS is not able to obtain RHC utilization data given the consolidated billing of G0511. The ability to collect data like this, and to better understand the similarities and differences in what specific care management services safety-net providers offer, in comparison to fee-for-service providers, further supports our recommendations above to reconsider the current G0511 billing methodology.

Beneficiary Consent Clarification
NARHC appreciates the clarification that CMS provided related to beneficiary consent for CCM and Virtual Care Communication, in that consent can, but is not required to be done at the initial visit for CCM done by the RHC practitioner, that it may be obtained under general supervision, and that it can be a verbal consent so long as documented in the patient's medical record.

Social Determinants of Health G-Code
NARHC supports the CMS proposal to reimburse for a Social Determinants of Health (SDOH) risk assessment, furnished in conjunction with an E/M visit, in recognition of the value of a comprehensive medical *and* social history. For the purposes of these proposals, CMS considers SDOH to mean "economic and social condition(s) that influence the health of people and communities." This includes food insecurity, transportation insecurity, housing insecurity, etc.

Many of the over 60% of people living in rural America that are served by RHCs face these economic and social conditions.

We commend the proposal to add the standalone SDOH risk assessment tool to Medicare's telehealth list, which allows RHCs to provide and bill for this service through December 31, 2024, as G2025. However, for in person visits during which a SDOH screening is performed, **NARHC urges CMS to permit RHCs to bill for this service**, either through the creation of a separate G-code, or by appropriately incorporating it into whatever alternative approach CMS considers for care management services in RHCs.

Conditions for Certification - Nurse Practitioner Definition Change

Certifying Authority -§491.2(1)
Currently, only two organizations have the authority in the RHC regulations (§491.2(1)) to certify NPs to practice as primary care NPs in RHCs, the American Nurses' Association and the National Board of Pediatric Nurse Practitioners and Associates. NARHC appreciates the CMS acknowledgment that there

are various other national certifying organizations with standards for Nurse Practitioners that more fully represent available certifications available for NPs. **Therefore, we support the proposal to expand the breadth of allowable certifying entities to better capture the full suite of NPs adequately trained to provide care in RHCs.**

Primary Care Certification
NARHC appreciates CMS seeking comment on whether the definition of nurse practitioner at §491.2(1) should continue to require that the NP's certification be in primary care or whether this should be removed. **NARHC supports the removal of the "primary care" specification, with the understanding that NPs will continue to provide services only within their scope of practice.** Yet, such a change increases the flexibility of RHCs to utilize the providers best equipped to join their care delivery team, without limitations that such a specification may require.

Other Provisions Not Addressed
NARHC thanks CMS for the significant amount of RHC related provisions in this year's proposed rule and looks forward to further engaging on the concerns outlined above in order to ensure that RHCs can fully utilize these expanded flexibilities. We were hopeful that CMS would use this rulemaking opportunity to address three additional topics of interest and concern to the RHC community which are discussed below.

Annual Wellness Visit as Separate Medical Visit

For preventive services furnished in RHCs on the same day as another medical visit, other than initial preventive physical examinations (IPPEs), RHCs receive their all-inclusive rate for only a single billable visit as these services are not eligible for same day billing, i.e., two visits billed on the same day and separately reimbursed. This policy creates a disincentive for RHCs to provide Annual Wellness Visits.

As CMS continues to make significant strides towards increasing access to preventive care for Medicare beneficiaries, it is essential that RHCs are adequately reimbursed when these services are provided to their patients. **NARHC encourages CMS to further amend the definition of an RHC medical visit, section (c) Visit-Multiple to the following:**

(c) ***Visit—Multiple***.
(1) For RHCs and FQHCs that are authorized to bill under the reasonable cost system, encounters with more than one health professional and multiple encounters with the same health professional that take place on the same day and at a single location constitute a single visit, except when the patient—
(i) Suffers an illness or injury subsequent to the first visit that requires additional diagnosis or treatment on the same day;
(ii) Has a medical visit and a mental health visit on the same day; or
(iii) Has an initial preventive physical exam visit, **or annual wellness visit,** and a separate medical or mental health visit on the same day.

Registered Nurses Performing Annual Wellness Visits

RHCs are only able to bill for Annual Wellness Visits (AWVs) if the patient is seen by an RHC practitioner. However, in traditional office settings, Registered Nurses (RNs) are permitted to complete all aspects of AWVs. This current policy creates a disparity between the two outpatient settings and makes it more difficult for AWVs to be performed in the RHC setting. As highlighted in various aspects of this year's proposed rule, CMS continues to make preventive and higher quality care a priority. **NARHC encourages CMS to further amend the definition of an RHC visit, section (a) Visit-Medical to the following:**

(a) ***Visit—General***.
(1) For RHCs, a visit is either of the following:
(i) Face-to-face encounter between a RHC patient and one of the following:
(A) Physician.
(B) Physician assistant.
(C) Nurse practitioner.
(D) Certified nurse midwife.
(E) Visiting registered professional or licensed practical nurse.
(G) Clinical psychologist.
(H) Clinical social worker.

(ii) Qualified transitional care management service.

(iii) Annual Wellness Visit.

RHC Urbanized Area Issue Finalized Policy
In March 2023, CMS released interim guidance on the process it will be utilizing to determine RHC rural location eligibility "while considering the most effective options for modifying its processes to align with the Census Bureau changes." NARHC is working with Congress to amend the statutory language and provide long-term clarity. We thank CMS for issuing this interim guidance and its use of both 2010 and 2020 maps to determine eligibility. We were pleased to see that this policy mostly preserves the historical location eligibility (areas of less than 50,000 people) for the RHC program, as we requested in our advocacy. Until Congress clarifies the issue in statute, we believe it would be beneficial to the RHC community if **CMS were to propose a more permanent policy on this issue**.

Conclusion

Your consideration of these comments/questions is appreciated. Should you have any questions or need any additional information, please do not hesitate to contact Nathan Baugh or Sarah Hohman at (202) 544-1880.

Sincerely,

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